INTRODUCTION

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The medical humanities, we claim, names a series of intersections, exchanges and entanglements between the biomedical sciences,[1] the arts and humanities, and the social sciences. *The Edinburgh Companion to the Critical Medical Humanities* introduces the ideas, individuals and scholarly approaches that are currently shaping the field. The medical humanities is an area of inquiry that is highly interdisciplinary, rapidly expanding and increasingly globalised. As this Introduction and the chapters that follow demonstrate, *The Companion* is both a reinvigoration and a critical reorientation of the medical humanities: an identification of new challenges for research, which also expands the methodologies, perspectives and practices that might be called upon to meet them.

This Introduction begins by identifying and analysing a 'primal scene' that has dominated the first wave of the medical humanities. Focusing on the communication to the patient of a diagnosis of cancer, we position this scene as symptomatic of the imaginary of first-wave or mainstream medical humanities, asking what it might have to tell us about the identity – and also the anxieties – of the field. In framing our discussion of the field, we speak of first-wave or mainstream medical humanities, and refer to the critical medical humanities as the second wave. In doing so, our aim is not to set up an oppositional or binary structure within the medical humanities but rather to indicate that medical humanities is a fluid notion, which is likely to shift and develop as scholarly fashions, health focuses and political contexts change. We are not, then, claiming the critical medical humanities as the final word, but rather as an encapsulation of the field's current momentum, and with an anticipation of more waves yet to come.[2] We move on to examine how the medical humanities is currently expanding and reorienting itself, embracing new historical, cultural and political perspectives, as well as different questions and methodologies. We ask what, precisely, is 'critical' about the critical medical humanities, examining how the field mobilises the notion and practice of critique, as well as how it orients itself in relation to other 'critical' turns. The Introduction also offers readers a series of pathways through the volume, focusing first on the four thematic sections – 'Evidence and Experiment', 'The Body and the Senses', 'Mind, Imagination, Affect', and 'Health, Care, Citizens' – before suggesting alternative trajectories based on discipline, period, spaces/sites, and thematic and methodological concerns related to violence and to questions of authority and expertise.

The 'Primal Scene' of the Medical Humanities

Our starting point is neither the history nor the identity of the medical humanities[3] but its imaginary, which, we suggest, is structured around the clinical encounter between the doctor and the patient: more specifically, the scene that unfolds the diagnosis of cancer.[4] Investigations of this scene, whether empirical, philosophical, literary or historical, have placed a humanist emphasis on individual protagonists and the role of narrative, metaphor and gaps in communication within the dynamics of the clinical interaction. A focus on the lived body of the cancer patient qua patient has tended to divert attention away from dimensions of gender, class, race, sexuality and debility within this scene; the specific health policies and practices that shape it in time and place; and its material and economic underpinnings. The fact that the scene does not announce its cultural, historical and institutional setting speaks powerfully to the implied or assumed generality of a UK and US mainstream. Far less is there a focus on 'non-medical' notions of health, illness and wellbeing; the production of clinical knowledge; or the sense that humanities and social sciences might play a constitutive role in shaping such knowledge. Rather, the staging of scholarly authority within the scene entails that the humanities act, or are positioned, as a kind of third party to it: the humanities are looking at medicine looking at the patient.

Our point here is not to suggest that the moment of cancer diagnosis is somehow an unimportant topic or an otherwise unsuitable object of scholarly inquiry; rather, we are interested in the question of why this scene has come to matter so much in and to the field, what interests might be invested within it, and what is potentially occluded from view – both within the scene itself and in relation to other sites and modes of inquiry.

We need to open up possibilities for the medical humanities to operate in radically different arenas of critical consideration, to address difficult, more theoretically charged questions, and to claim a role much less benign than that of the supportive friend.[5] How might the bodies of doctors and patients be marked in terms of race, class, gender, ability and disability, and with what effects? What else, we might ask, is in the room, and with what forms or modes of agency might it be associated? How might we account for non-human objects and presences, for belief systems, and even for the diagnosis itself – what, for example, is its history, or its status as a performative act? Where and when else might the scene be situated, and what difference would this make? The critical medical humanities thus does not represent a rebranding exercise, but rather an attempt to pose more critical questions; to re-envisage the scene, perhaps with a critique of the way in which it has been addressed so far by medical humanities scholarship.

As well as interrogating the primal scene, the critical medical humanities goes further to explore new scenes and sites that may be equally important to our understandings of health and illness – the laboratory, the school policy, the literary text. We thereby aim to understand how concepts, frameworks and data operate in more public spheres. This widening of focus is also a call to reflect on the ways in which

the humanities and social sciences are themselves taking up medical concepts. How do they align themselves with medical ideas in their theorisations and operations? What aspects of biomedicine have become prominent in these disciplines, and which are under-represented? How might we productively rethink the notions of collaboration and interdisciplinarity that are integral to our project of expanding the frame of inquiry?

The Three 'Es' of Medical Humanities

We have noted that the 'primal scene' of mainstream medical humanities has focused the gaze in a particular way. It also gives rise to and binds together our version of the three 'Es' that have shaped and defined the field: ethics (medical ethics and bioethics), education (medical, but also increasingly health) and experience (particularly qualities of illness experience). In what follows, we will briefly discuss each category in turn, before moving on to ask how the critical medical humanities might refocus and redirect our attention. Specifically, we argue in this Introduction that the critical medical humanities organises itself in relation to a new 'E': the concept of entanglement.

In order to capture a defining moment of first-wave medical humanities in the UK, we turn to Arnott et al.'s 'Proposal for an Academic Association of the Medical Humanities' (2001). Summarising the then emergent field, Arnott et al. note:

> 'The medical humanities' is, in the United Kingdom, a relatively new term for a sustained interdisciplinary inquiry into aspects of medical practice, education and research expressly concerned with the human side of medicine. These are, most especially, the nature, importance and role of human *experience* on the part of patients and practitioners alike, including their experience of the patient–practitioner relationship.
>
> Historically the first and most obvious feature of this inquiry was the modern exploration of medical ethics. 'The medical humanities' is the name of a more inclusive inquiry, though one that embraces ethics.[6]

If the field of medical humanities is here positioned as developing out of and expanding that of medical ethics, this intellectual lineage also focuses its attention on issues where moral values are in doubt or crisis. Medical ethics, and more recently bioethics, thus bring into prominence for the medical humanities end-of-life care and decision-making, as well as reproductive medicine. At the same time, medical ethics prioritises effective communication across and between all stakeholders in the healthcare setting or context. We do not wish to deny that these are valid and important sites of inquiry; rather, we seek to trace how the specific concerns of medical ethics might have shaped and influenced what has come to matter in and for the medical humanities. Returning to our 'primal scene', we can readily discern within it hallmark concerns with (potential) end-of-life care and decision-making, and effective patient–practitioner communication.

Our 'primal scene' can also be seen to be expressive of a notable anxiety regarding the effectiveness, in terms of empathy rather than of accuracy or truth-telling, of the doctor's communication of the cancer diagnosis to the patient, and this leads us to the second of our three 'Es': education. Under the influence of the US, where medical humanities programmes have been predominantly based in medical education, the first wave of the medical humanities in the UK also developed a strong pedagogical focus. Central to the emphasis on medical training was a specific interest in, and concern about, issues of communication. Arnott et al. observe:

> Patients have detailed knowledge of their own experiences of illness. Doctors have detailed scientific knowledge of disease processes. These two kinds of knowledge appear very different, and bringing them together is not straightforward. If done successfully, then both patient and doctor have a shared understanding which could be said to be 'intersubjective' knowledge.[7]

Operating within a series of binaries (patient/doctor, illness/disease, medicine/humanities), first-wave medical humanities aimed to produce a shift in clinical method towards attending to and interpreting patients' subjective experience as well as scientific knowledge and data. The field developed new curricula and educational materials, which sought to draw the perspectives and modes of inquiry of the humanities and social sciences into medical and health education. While the role of the humanities and social sciences in medical and health education remains a central concern of the field as a whole, it is not our focus in *The Edinburgh Companion to the Critical Medical Humanities*. Instead, where pedagogy does come into view, contributions to this volume look not to specific aspects of curricula but to the concepts and politics underpinning them and to how models of interdisciplinarity, or even of postdisciplinarity,[8] might be rethought in a mode that does not assume already existing territories of knowledge. In expanding our range and scope of inquiry, our aim is not to produce a new binary between teaching and research, areas of activity that are rightly and necessarily intertwined, but rather to consider how a critical reorientation might potentially invigorate both aspects of the field.[9]

Integral to the incorporation of the humanities into medical education was a focus on the illness experience, a category that has been of particular significance to mainstream medical humanities. In establishing curricula, proponents of first-wave medical humanities accordingly privileged texts that provided a realist account of a particular medical condition. For the patient, narrative was seen to provide an effective vehicle for articulating illness, and to hold potentially transformative value.[10] For the practitioner, narrative competence was integrated into training for clinical diagnosis and treatment.[11] Following Angela Woods's influential critique of narrative's dominance in the medical humanities,[12] this volume opens up the question of the function and status of the literary text, and of what kind of evidence it represents. The issue of narrative's position in the critical medical humanities is addressed by Brian Hurwitz and Victoria Bates, who contend that it still has a central role to play. The debate is developed by Laura Salisbury, who argues for a distinction between narrative and language, proposing that the experimental and

non-realist modes of modernist texts might offer a useful model for representing illness. The critical medical humanities is also invested in non-literary forms of representation, and the chapters on visual culture in this volume could readily be supplemented by thinking about the potential of music, or of hybrid forms such as the graphic novel, for capturing and conveying patient experience.[13]

More than this, the critical medical humanities questions the value accorded to empathy (itself a fourth and final 'E' that might be added to our list) in first-wave medical humanities. The positioning of narrative as 'the cure-all for an increasingly mechanical medicine' through the production of 'more empathic' practitioners has recently been critiqued by Jeffrey Bishop, on the grounds that it 'perpetuates a dualism of humanity that would have humanism as the counterpoint to the biopsychosociologisms of our day'.[14] This is an important point, and one that finds echo in our volume from Des Fitzgerald and Felicity Callard, and from Patricia Waugh. In reorienting the question of experience, the critical medical humanities insists that we move beyond the assumption that all affect and feeling are to be found in the arts and humanities, and all hard-nosed pragmatism in the biomedical sciences. Rather, we begin to ask instead what the biomedical sciences might have to tell us about empathy, or how the arts and humanities might speak of affective distance, and even a lack of care.[15]

Why the 'Critical' Medical Humanities?

The current valence of the term 'critical' in relation to the medical humanities in particular has been addressed by William Viney, Felicity Callard and Angela Woods in their introduction to a recent special issue of *Medical Humanities*.[16] Their discussion offers a rich starting point for beginning to think through the ways in which the 'critical' might most productively be aligned with the medical humanities, and what it might mean to do so. Turning first to postwar critical theory as a vital mode of generating social and political change, and as closely tied to activist movements, Viney, Callard and Woods cite the following as important intellectual landmarks: the Frankfurt School, the key proponents of which 'built on a much longer European tradition of written *critique*, of sustained and methodical analysis of a given object or process'; Michel Foucault's influential archaeologies of thought, which mobilised critique in an oppositional sense 'as a means to resist "presumptuous reason and its specific effects of power" '; the clarion call of Judith Butler to regard critique not simply as a rhetoric of negativity, but rather (or also) as a means of bringing about structural change; and Bruno Latour's characterisation of critique as a form of disruptive rebellion, making visible the assumptions and prejudices that are masked by the apparent neutrality and objectivity of science.[17] Pulling through these examples, taken from thinkers who differ radically in methodology and approach, are inevitable tensions regarding what critique is and might do (analyse, oppose, mobilise change); nevertheless, each writer can broadly be characterised as conceiving of critique as necessarily assuming a stance or mode of positioning in relation to a presumed object, which in the case of medical humanities would most commonly be conceived as biomedical science.

Globalising the Medical Humanities

Pausing for a moment over the landmarks selected by Viney, Callard and Woods, it is notable that these are explicitly located 'in European and US universities'.[18] Their list is complemented in this volume by numerous additional points of reference: to name a few, Sara Ahmed, Donna Haraway, Susan Sontag and Slavoj Žižek. However, this *Companion* also consciously expands the range and scope of those who might be viewed as key thinkers in the project of critique. This extension is, in the first instance, geographical. Thus, Volker Scheid – like Viney, Callard and Woods – returns to the Frankfurt School as a vital reference point for the notion of critique, citing German–Jewish philosopher Max Horkheimer to assert a model that is directed towards change and so inherently allied to the orientation of the medical humanities towards improved medical practice. Yet for Scheid, the project of the critical medical humanities in an era of globalisation aptly entails thinking through Horkheimer's understanding of critique in dialogue with that of early twentieth-century Chinese philosopher, revolutionary and medicine scholar Zhang Taiyan. Reflecting his own complex positioning as at once Western academic and practitioner of Chinese medicine, Scheid advances his own clarion call for a critical medical humanities that would not only embrace different influences and points of departure, but that might also think more carefully about who and what are positioned as subjects and objects of inquiry, and with what effects:

> If the medical humanities truly intend to become a space for critique rather than mere criticism, its practitioners will need to find ways of moving beyond the modern constitution that defines and constrains them, not least through their one-sided attachment to biomedicine.
>
> [I] argu[e] that opening ourselves up to non-modern medical traditions, not as objects of inquiry but as resources for thinking critically about the fundamental issues of our time, presents an opportunity for doing precisely that.[19]

Scheid's inclusion of Zhang Taiyan as an intellectual companion on the journey towards a critical medical humanities might readily be complemented by other thinkers who would extend its reach beyond the European and US academy. Martiniquan psychiatrist and revolutionary Frantz Fanon, for example, also still has much of relevance to offer, not least on the inescapable imbrication of biomedicine in social, political and institutional structures, and on questions of pathology and resistance.[20] Nor should the project of critique be reserved exclusively for those who might broadly be termed critical thinkers: in her self-conscious turn to alternative geographies not usually encompassed by the medical humanities, Rosemary J. Jolly makes a case for the role of creative practitioners in critically exploring transcultural medical encounters, not least because their methods often lend themselves to the opening up of issues rather than to definition or assertion.

The Critical is/as Historical

By also insisting upon the inclusion in the critical medical humanities of historical perspectives that might offer an alternative mode of moving beyond the dominant

paradigm of biomedicine, Scheid's work joins other contributions to this volume in which period specialists across a range of disciplines reflect on the 'critical' value of paying attention to the past (or rather, to a number of different pasts). Broadly summarised, three main arguments can be advanced for what historical perspectives might bring to the project of a critical medical humanities.[21] First, they offer alternative vantage points from which to view, reflect on and critique the biomedical. Corinne Saunders, for example, draws on medieval representations of the interrelation between mind, body and affect to explore the surprising ways in which pre-Cartesian perspectives chime with current neuroscientific approaches; Lauren Kassell positions the early modern as a period of information revolution driven by the advent of paper technologies, and asks how the ways in which medical knowledge was recorded and organised might inflect our sense of the current digital revolution; and Cynthia Klestinec parallels the expanding and competitive early modern medical marketplace to our own time, reflecting on how and why patients trust practitioners and comply (or not) with their instruction. Moving to the nineteenth century, Lindsey Andrews and Jonathan M. Metzl argue that historical imaging practices render visible in present imaging technologies a troubled racial legacy, while Heather Tilley and Jan Eric Olsén locate in the period a shifting and unstable discourse on the senses, which opens up new perspectives on the representation of blindness. Here, then, the historical is used to locate and identify points when medical traditions and practices are being contested and developing in new ways, and these sites of transformation provide the stance or position from which the object of biomedicine can be viewed and critiqued. Secondly, a historical perspective can enable us to attend to different forms of qualitative critical thinking – and different ways of sensing our world – that were important in the past and that may remain with us today, even if we have lost the vocabulary to describe them. Jennifer Richards and Richard Wistreich highlight through their discussion of medical accounts of early modern voice the vitality of disputation as a way of thinking that was highly valued from the medieval period up to the nineteenth century and as one that could recognise uncertainty and allow for scepticism. Peter Garratt identifies in nineteenth-century aesthetic and psycho-scientific discourses a notable tension or equivocation between reading as injurious to health and reading as therapeutic resource, arguing that current attitudes towards reading and health would benefit from a longer historical perspective. Finally, thinking historically can, as Fitzgerald and Callard point out, help us to understand the extended, continual and shifting process of negotiation through which certain objects and practices come to our attention and others fade from view. Ian Sabroe and Phil Withington, for example, argue for the importance of attending historically to the language of medicine and health; tracing the shifting fortunes and resonances of the word 'counsel', they bring into view a movement away from the clinical encounter as conversation. Across the various modes of engaging (with) the historical, the contributors' detailed and nuanced reflection on how past and present contrast, counterpoint and complement each other collectively resists a simplistic, or moralistic, narrative of historical change.

Institutions, Opposition, Implication

It is clear, then, that in terms of a project of critique, a particular geographical location or historical period can offer an effective vantage point from which to (re)view Western biomedicine. Elsewhere in the volume, contributors have chosen as an alternative focus specific institutional structures, histories and practices: Lucy Burke, for example, examines UK care institutions; Lisa Guenther, the execution chamber of the American penal system; and Anna Harpin, the history of theatre at the notorious Broadmoor psychiatric institution. Alternatively, specific illnesses, including their designation as such by biomedicine, can provide the grounding for discussion: Jane Macnaughton and Havi Carel engage with the symptom of breathlessness, and particularly with the diagnostic category of chronic obstructive pulmonary disease (COPD), while Bethan Evans and Charlotte Cooper examine the ways in which fatness has been framed within clinical and public health discourses. Each of these approaches opens up new critical perspectives on biomedicine, leading inevitably to the question: What, then, is the 'critical' work that is being enacted in and through the critical medical humanities? The response, in the context of this volume, is neither simple nor singular. Many of our contributors express a commitment to the legacy of critical theory, and its often explicit alliance to social and political activism, to write in opposition to contemporary biomedicine: see, for example, Sarah Atkinson, Burke, Luna Dolezal, Evans and Cooper, and Guenther. *The Companion* recognises the importance of continuing and revitalising a tradition of antagonistic thinking; we do not wish to forget or to underestimate the potential to effect change of criticism with purpose, and Ahmed's model of the killjoy, quoted by Evans and Cooper, stands as a powerful figure for this mode of praxis.[22] Feminist theory has emerged as a particularly energising and dynamic undercurrent running through many of the chapters, and it should perhaps come as no surprise that this intellectual tradition, which has engaged so attentively with, amongst others, questions of the medical, the gaze, the body, affect, power and resistance, should make its presence felt in the current collaborative project of articulating a critical medical humanities.

The Companion also, however, claims an alternative vision of the 'critical', which is based not in opposition but in implication. We arrive here, then, at the 'E' of the critical medical humanities: the notion of entanglement. This term has recently been defined by Viney et al., who assert that the critical medical humanities would do well to be wary of an antagonistic mode of thinking, embracing instead the heterogeneous and partial positions and practices that often define research in the field:

> Many actors who populate the medical humanities are, we should recall, specialist multi-taskers: they collaborate across and between disciplines, inside and outside of clinical and para-clinical spaces, and frequently move from the position of patient to clinician to researcher to future patient. In such movements are born new practices and alliances that course across methodologies, epistemologies, kinds of experimental space and design.[23]

Here, then, the critical medical humanities is based in mobility, fluidity, movement: a creative boundary-crossing in and through which new possibilities can emerge.

A legacy of feminist theory can again be seen at work in the concept of entanglement, notably in feminist philosopher Karen Barad's influential work on agential realism. In their opening chapter to *The Companion*, Fitzgerald and Callard elaborate on the concept of entanglement, harnessing and revitalising Barad's ideas in the context of the critical medical humanities. Central to Barad's thinking is the idea that phenomena do not precede their observation (and hence require the development of increasingly sophisticated technology and equipment to discern and measure them) but rather emerge – or, alternatively, fail to take on determination – in and through the coming together of particular material assemblages, which include the experimenter, the object of the experiment, the experimental apparatus and the laboratory setting. Barad refers to the complex intra-action between these various elements, which, she argues, has far-reaching implications:

> In particular, I propose 'agential realism' as an epistemological-ontological-ethical framework that provides an understanding of the role of human and nonhuman, material and discursive, and natural and cultural factors in scientific and other social-material practices, thereby moving such considerations beyond the well-worn debates that pit constructivism against realism, agency against structure, and idealism against materialism. Indeed, the new philosophical framework that I propose entails a rethinking of fundamental concepts that support such binary thinking, including the notions of matter, discourse, causality, agency, power, identity, embodiment, objectivity, space, and time.[24]

One could readily add to Barad's list of 'well-worn debates' the pitting of the humanities against medicine and, for the project of a critical medical humanities in particular, her model holds interesting potential. Fitzgerald and Callard observe that we might extrapolate from Barad's insistence on the necessary implication of the experimenter with her apparatus a fundamental recalibration of scientific and medical authority. Additionally, Barad's repositioning of science not as objective knowledge but as a set of material-discursive practices that configure what comes to matter – as well as what does not – can, in the context of the critical medical humanities, call our attention to the inescapably political dimensions of biomedical research. If the field of medical humanities has to date focused predominantly on political and ethical questions concerning patient–practitioner interaction and beginning-/end-of-life care, Fitzgerald and Callard note that the critical medical humanities might usefully enter into and intra-act within the medical research laboratory, asking: 'how might the methodological and intellectual legacies of the humanities intervene more *consequentially* in the clinical research practices of biomedicine?'[25] In this sense, the 'critical' marks an ambition to see the humanities more fully embedded into biomedical research, beyond the clinical encounter per se.

Critical Entanglement

The model of the 'critical' that is advanced by Fitzgerald and Callard resonates through a number of chapters in *The Companion*. It is taken up first by Annamaria

Carusi in her analysis of modelling practices in systems biomedicine. As a humanist scholar who has entered into close collaboration with biomedical researchers, Carusi echoes Fitzgerald and Callard in registering a shift away from the dualistic and the oppositional as modes of describing and thinking through the complex, enmeshed relations of the research laboratory: 'I consider how . . . non-dualist frameworks open up different ways of thinking about systems biomedicine and the implications for ourselves as "digital patients" [, as well as] the responsibilities this implies for the critical humanities medical scholar.'[26] Carusi's point here is a powerful one with regard to the critical medical humanities: if we take seriously the project of reconceiving how ways of knowing and acting, how bodies, technologies and environments are intertwined, then we also need to commit ourselves to the intellectual responsibilities that emerge as a consequence.

William Viney's chapter also turns its gaze to the research laboratory, examining the use of twins in biomedical experiments. For Viney, too, it is crucial to think beyond the binaries that have so far characterised the medical humanities:

> One of the challenges when developing a 'critical' agenda in the medical humanities has been to suggest alternatives to this adversarial thinking, to do more than sit on the sidelines decrying the poor ethics of others and the statutory importance of 'humanity'. This process might begin by acknowledging how medical and health-related knowledge, care, intervention, education and research are extensively, complexly and unevenly distributed throughout social life, deeply and irrevocably entangled in the vital, corporeal and physiological commitments of biomedical research.[27]

Negotiating the question of the 'human', Viney interrogates what happens when the experimenter in twin research regards herself as separate from her subject(s), and the ethical and political repercussions that can arise. He also applies the concept of entanglement to the category of the human itself, drawing on Mel Chen's sliding scale of animacies[28] to challenge the fixed categories of human/non-human and to explore alternative, more flexible and open epistemologies, concluding that: 'Such a view promises to open up the thingliness of specific people that refuses biological essentialism and recognises how animate identities can be internally external, born and raised, materially and dynamically distributed with and between bodies.'[29] Viney regards the task of rethinking the category of the human to be particularly urgent as biomedical research increasingly highlights its material and molecular dimensions; twins offer a valuable focus because of their historical, and troubled, positioning as sites of experiment and measurement.

Finally, David Herman also turns to the questions of implication that are embedded in the concept of entanglement to think through the assemblage of bodies and subjectivities that is put in play in and through animal assistant therapies. Focusing on the representation of animal assistants in narratives of autism, Herman identifies the complex and multi-layered ways in which the binaries of human/non-human and able/disabled are unsettled and complicated, raising powerful questions of agency and, to return to Barad's phrase, intra-action. Although Herman's focus on the human/animal

intersection addresses animal assistants specifically, it also has resonances with the use of animals in biomedical research experimentation, and reads suggestively in conjunction with Viney's chapter if viewed in this light.

Phenomenology and the Critical

We have argued thus far in this section that feminist criticism has emerged as a strong presence in this volume, leading on the one hand to a politics of antagonism, and on the other hand to a politics of implication. Another key area of critical potential, although it can sit uneasily at times with critical theory, is phenomenology.[30] Again, this should perhaps come as no surprise, given that this branch of philosophy has produced a sophisticated mode of description for many of the key terms highlighted in the sections of *The Companion*: body, senses, mind, imagination and affect. More recently, phenomenology has been revitalised through its intersection with philosophy of mind and critical neuroscience, and Shaun Gallagher has been particularly important in theorising concepts of intersubjectivity and embodied cognition.[31] In this volume there are four key ways in which phenomenology is positioned in relation to the critical medical humanities. First, phenomenology can be productively harnessed to a politics of opposition to the biomedical, in its privileging of the first-person perspective. Thus, in the context of the lived genome, Christoph Rehmann-Sutter and Dana Mahr turn to Edmund Husserl on the life world, to argue for the importance of phenomenology in countering an exclusively biomedical understanding of genetically related disorders. Jill Magi, Nev Jones and Timothy Kelly also return to Husserl to articulate a powerful critique of how the first-person perspective has been integrated into studies of psychosis, and the issues of voice and representation that it raises:

> The first-person experience of psychosis most often appears in scholarly work as 'evidence' for an often dispassionate *other* to interpret. Rigorous work on the phenomenology of psychosis has been carried out almost exclusively by those without claim to the first-person lived experience . . . Nevertheless, we ask, might phenomenology, as articulated in Edmund Husserl as a disciplined engagement with *first-person* experience, provide closer access to psychosis, 'originarily'?[32]

In this sense, then, the critical medical humanities continues a trajectory already established in first-wave medical humanities, although with a closer attention to whose voice is deployed, how, and with what effects.

Secondly, phenomenology is viewed in its historical and cultural context. Edmund Juler accordingly compares phenomenology with the parallel movement of psychophysiology, arguing that while the former attended to somatic experience as part of a broader investigation into perception, the latter focused its account of the self in neuropathology. Laura Salisbury's account of phenomenologist Maurice Merleau-Ponty complicates this view, contending that recent neurological advances in aphasia were central to Merleau-Ponty's representation of our meaningful relations with the world. In spite of their differences in perspective, both of these chapters attend to phenomenology within its own

cultural moment, positioning it as *already* engaged with, and defining itself in relation to, medical debates and discourses.

Thirdly, contributors to this volume are concerned with how phenomenology might be applied in medicine today. Here, there is a marked emphasis on the relevance of phenomenology beyond clinical neuroscience, where it has already been influential: Jonathan Cole and Shaun Gallagher argue for its significance across a range of chronic physical disorders, while Macnaughton and Carel contend that in the context of COPD it could usefully counter an overdependence on brain imaging technologies. In the critical medical humanities, then, there is a notable extension of phenomenological approaches towards the management of long-term physical conditions, including pain.[33]

Finally, phenomenology is also harnessed in this volume towards the project of entanglement, in particular through its attention to the intersection between inner and outer. Thus, Carusi turns to Merleau-Ponty to articulate a model of the measuring body that seeks to move beyond duality and towards intertwinement; Viney, on the other hand, articulates suspicion of phenomenology's dualist tendency to distinguish between human inner and non-human outer, and looks instead to vital materialism for a more dynamic model of inter-relationality. While phenomenology thus remains central to the critical medical humanities, it is significantly interrogated, historicised and destabilised, and is also thought through in relation to different medical contexts and conditions.

Critical Medical Humanities: A Turn Among Many?

Having thus identified the critical work that the critical medical humanities might be said to do, and the important influences from critical theory that inform its project(s) of critique, it now remains to address the intersection of the critical medical humanities with other relevant 'critical' turns in contemporary scholarship. Arguably of most significance here is the emergence of critical disability studies. Characterised by Margrit Shildrick as a reassessment of the aims and assumptions of twentieth-century disability studies,[34] the field revisits questions of care, the body and activism in the context of economic austerity. In doing so, critical disability studies moves beyond the Marxist-materialist frameworks that were dominant in disability studies, looking also to feminist, queer and postcolonial theoretical models.[35] At the same time, there is also a move to extend the geographical scope of disability studies beyond the global north, in terms of asking how disability is configured in the global south and also by addressing subaltern traditions of resistance and activism.[36] In *The Companion*, the concerns of critical disability studies can be felt most evidently in the fourth section, 'Health, Care, Citizens'. Burke and Harpin both interrogate, in the contexts of dementia and criminal pathology respectively, the notion of 'care' in relation to mental health. Other chapters in this section are more closely aligned to the globalising agendas of critical disability studies: Atkinson also focuses on the concept of care, or more precisely its failure or absence, in the context of the global organ trade;

Hannah Bradby criticises dominant conceptual models of the global migration of medical and health professionals for their focus on resource and regulation; and Jolly makes visible hidden alliances between biomedicine in the global south and colonising philosophies. Unsurprisingly, the concerns of critical disability studies also emerge in the 'Body and the Senses' section: here, Evans and Cooper argue for the productive intersection of fat studies with queer and disability theory, and Tilley and Olsén think about how blindness was constructed as a disability in the nineteenth century, looking in particular at how emergent technologies of touch could act either to enable or to disable the blind through rendering them as active or passive recipients of knowledge. Critical disability studies can thus be seen to intersect with the critical medical humanities in the politicisation and theorisation of the body, and in the politics and ethics of care.

The second critical turn that might usefully be signalled as relevant to the critical medical humanities is the development of critical animal studies. Emerging as a movement in philosophy at Oxford in the early 1970s, the field has recently gained significant ground, and currently constitutes a vibrant and rapidly growing multidisciplinary movement, with its own journal and monograph series.[37] Of most relevance to this volume is the interest of the field in critically reassessing the animal/human boundary; while this informs Herman's chapter most explicitly, the inherent concern of critical animal studies with reconfiguring questions of agency and affect also intersects with the interests of Fitzgerald and Callard, and of Viney.[38] Also central to critical animal studies is the question of animal rights, and here future work in the critical medical humanities might usefully address how the body of the animal comes to matter not only in therapeutic/clinical contexts but also in the biomedical research laboratory.[39] Critical disability studies and critical animal studies are both influenced by a broader turn towards questions of human rights within the academy,[40] and this too engages with the concerns of the critical medical humanities: see, for example, Guenther on the implication of biomedicine in US penal execution practices, or Viney on the dark history of twin research.

Other key 'turns' that are also resonant with the critical medical humanities can be identified as follows: the digital turn, which at once raises questions around the integration of digital technologies into biomedicine (Andrews and Metzl, Dolezal) and enables 'big data' scholarship in the arts and humanities, opening up new research methodologies and questions (Kassell, Sabroe and Withington); the visual turn, which fosters a critical interrogation of the reliance of biomedicine on imaging technologies and the identification of alternative practices (Macnaughton and Carel, Richards and Wistreich), as well as an attentiveness to the visual arts as mode of intervention and critique (Rachael Allen, Suzannah Biernoff, Juler); and finally the material turn, which has reoriented the traditional focus of the humanities on culture, mind and language towards an emphasis on nature, bodies and things, and which underpins this volume's deep investment in the ineluctable materiality of discursive praxis (see, for example, Martyn Evans on the body as vibrant matter, or Richards and Wistreich on the anatomy of voice).[41] Of particular resonance here is the recent emergence of

feminist materialism, and key critics alongside Barad include Elizabeth Grosz, Donna J. Haraway and Elizabeth A. Wilson.[42] The importance of these scholars for the medical humanities is signalled by Stacy Alaimo and Susan Hekman in their introduction to the edited collection *Material Feminisms*: they observe that without a sophisticated discourse for describing bodily materiality, it is 'nearly impossible for feminism to engage with medicine or science in innovative, productive, or affirmative ways – the only path available is the well-worn path of critique'.[43] While marking a distinctive turn within the medical humanities per se, *The Companion* thus also registers the inevitable intertwining of this shift with broader developments across the arts and humanities; thinking rigorously and flexibly across existing – and emergent – points of interconnection will be both vital and energising to future scholarship in the critical medical humanities.

Critical Mass and Urgency

Tracing a line of influence from critical theory into the critical medical humanities, and indicating how this intellectual genealogy inflects the modes of critique that are at work in the field, we have endeavoured here to map out – albeit in a very preliminary form – how a 'critical' medical humanities might be positioned within, and intersect with, a range of other recent 'turns' across the arts and humanities. In doing so, we hope to have captured something of the dynamism and force of the term 'critical' within current medical humanities scholarship; however, there are two alternative significations of the word that have also taken on particular meaning in the course of working on the volume. First is the idea of critical mass: the sense of a gradual gathering in numbers, a cumulative growing in density, which eventually reaches a tipping point. The chapters in this volume transmit, necessarily in partial form, the vibrancy and the diversity of critical attention that is being paid to medicine and health across a range of disciplines and practices, from diverse international contexts and communities, and by scholars both new and established. Placed together with the direction taken by major journals in the field, the impetus provided by international funding bodies, and the recent surge in medical humanities research centres and institutes within the academy, the momentum for the critical medical humanities seems to be gathering pace. Relatedly, then, we call attention to a sense of urgency and imperative that is also embedded within the term 'critical'. *The Companion* represents not a definitive statement on the critical medical humanities, nor an outlining or demarcating of its boundaries, but rather the response to and representation of a moment of emergence, one that registers and records a growing mass or density, a vital animacy, in a field that is at a crucial point or nexus of growth, shift and change.

Pathways through *The Companion*

Pressing on the term 'medical' and taking a view of the humanities that extends to encompass the arts and social sciences, the critical medical humanities widens still

further the scope of a heterogeneous field that is not easily characterised by shared disciplinary orientations, methodologies, audiences or areas of inquiry and intervention. This diversity is not domesticated in *The Companion* but actively embraced. Each of the four thematically organised sections stages a dialogue across periods and disciplines, opening up new and often conflicting perspectives on what are emerging as key areas of interest in the critical medical humanities. The concluding chapters to each section do not have the final word in settling debates raised by the contributions; rather, by identifying what is at stake in, achieved by and missing from these discussions, the Afterwords reflect on where they might now lead.

Evidence and Experiment

The Companion opens with an exploration of 'Evidence and Experiment', juxtaposing ideas and issues that have been central to the logic, identity and anxieties of the medical humanities with those that take the field in new directions. The medical humanities has long understood itself as both challenge and corrective to the hierarchies of evidence that have come to define theoretical, practice-based and policy-oriented instantiations of the biomedical. Work in narrative medicine[44] and the phenomenology of health and illness[45] has succeeded in highlighting the limitations of evidence-based medicine while at the same time championing humanities-led approaches to making subjective experience more visible and valuable *as* evidence, particularly in clinical encounters. Evidence has also been a key concern for those arguing for an expanded mobilisation of the arts and humanities within therapeutic[46] and educational[47] settings: do medical humanities approaches 'work', and if so, how, for whom and in what contexts? The critical medical humanities chapters in this section drill more deeply into these issues, not just drawing attention to what is absent from or lacking in the evidence base of biomedicine, as do Rehmann-Sutter and Mahr in their persuasive analysis of 'The Lived Genome', but focusing as well on its generative potential, its capacity to produce new subjects and objects of knowledge, as Viney demonstrates in 'Getting the Measure of Twins'. This section also pushes the medical humanities to engage with new sites and modes of evidence production – from the modelling and data visualisations of systems biology, to the digitised archive of early modern casebooks, to the laboratory and experimental settings of contemporary neuroscience.

If evidence, then, is a staple concern of the medical humanities, and one that is addressed here in new and illuminating ways, the experiment – as site, methodology and aesthetic – is something these chapters argue is ripe for further exploration. In the opening chapter, Fitzgerald and Callard urgently call for 'a significantly reanimated research programme for the medical humanities'. Practices of 'entanglement',[48] they argue, move the field beyond the dualism implied by its name and, crucially, beyond the fantasies of holism to which mainstream medical humanities work has long been oriented. The notion of experimental entanglement is picked up by contributors across *The Companion*, resonating especially strongly in this section with Carusi's 'Modelling Systems Biomedicine' and Scheid's analysis of 'Holism, Chinese Medicine and Systems

Ideologies'. The final chapter in 'Evidence and Experiment' shows that these terms are inextricably entwined with two further concepts familiar from our discussion of the three 'Es' above – 'ethics' and 'experience' – except that now we are engaged, more precisely, with 'an ethics that demands an unwillingness to fix the essence of experience'.[49] 'What, if Anything, is the Use of Any of This?', Magi, Jones and Kelly ask in the concluding chapter to the section: a chapter that harnesses a poetics and politics of disruption to interrogate distinctions between the analysts and bearers of psychotic experience.

The Body and the Senses

The second part of *The Companion*, 'The Body and the Senses', looks afresh at one of the most important substantive topics of medical humanities research: the body as it suffers, bears and is transfigured by illness; the irreducibly subjective experience of embodiment that exceeds and eludes the quantified body of biomedicine. Although it has yet to be extensively documented, the medical humanities' contribution to the wider corporeal turn in the humanities and social sciences[50] is continued in the critical contributions of *The Companion*; however, without losing the focus on pain and the particular qualities of bodily suffering (such as in Macnaughton and Carel's discussion of COPD), this section takes the sensate body as a starting point. Tracing the interplays of sight and touch, voice and flesh, the chapters are alert to the ways in which our senses may not be shared, cannot be taken for granted, and find various expressions across historical, cultural and political contexts. Richards and Wistreich, for example, discover the historically elusive voice somewhat paradoxically at the heart of Renaissance anatomy in their analysis of 'embodied thinking'; Tilley and Olsén offer critical insights into the importance of touch in nineteenth-century thinking about visual impairment. The work represented in *The Companion* could usefully be supplemented by other recent projects, which construct and critically examine historical archives of smell and of the skin.[51]

The production of bodies and the means by which this is done – whether juridically, scientifically, aesthetically, or through the regulative frameworks of health and social policy – are central concerns of Andrews and Metzl's compelling critique of the legacy of racialisation in medical imaging, and Dolezal's examination of the morphological freedom of the posthuman. Continuing Magi, Jones and Kelly's critical reflections upon the tensions and (dis)continuities between scholarly endeavour, artistic practice and activism, Evans and Cooper's 'Reframing Fatness: Critiquing "Obesity"' and Allen's 'The Body beyond the Anatomy Lab' explore the ways in which our own bodies – as scholars, artists and activists – are sites through which knowledge is produced, political claims are staked, and experimental methodologies can be explored. Whether living or long dead, surgically transformed or stylistically rendered, our fleshy materiality, it is suggested, is something a critical medical humanities must grapple with in its complexity and diversity, weightiness and consequentiality.

Mind, Imagination, Affect

Far from being abandoned or declared resolved, the questions of corporeality raised in 'The Body and the Senses' continue to animate chapters in the third section of *The Companion*. Opening with Martyn Evans's reflections on the embodied human nature as scene and source of wonder, and going on to excavate the surrealists' enchantment with viscera and to interrogate medicine's role in the perverse logics of state-sanctioned execution, 'Mind, Imagination, Affect' resists any easy separation of mind and body, 'physical' or 'mental' pathology. Far from being universally recognised, these distinctions are peculiar to post-Cartesian thinking; the medieval thought world, as Saunders shows, 'illuminate[s] the complex inter-relations of mind and body, and probe[s] the power of affect in resonant and suggestive ways'.[52] Reaching from the late nineteenth century to the early twenty-first, neurology, neurological impairment and neuroscience are figured in chapters by Salisbury and by Cole and Gallagher as particularly fertile sites for understanding how the phenomenological, the aesthetic and the clinical can be mutually illuminating. The literary – understood as a critical orientation as well as a set of texts – also takes centre-stage in this section, though in ways that again signal a departure from more conventional medical humanities scholarship. If the field has so far been chiefly interested in literature's capacity to represent experiences of health and illness[53] and thus have moral, pedagogic and therapeutic value for readers as well as writers, the literary critical medical humanities, as envisaged here, is concerned more with opening up new perspectives on the history of ideas (including about the nature of mind, imagination and affect), and examining in detail the aesthetic and narrative strategies through which literary texts model cognitive and affective processes. As Garratt argues, this subtle but significant shift in approach 'further implies a need to ask critical, self-reflexive questions about how aesthetic assumptions are put to work methodologically in medical humanities research'.[54]

Health, Care, Citizens

'Health, Care, Citizens', the title of our fourth and final section, also marks out some intriguing areas for further exploration – the relationship between health and care as qualities, practices and policies; the ways in which citizens show, give, access and benefit from care; and the ways in which the health of the citizenry and the healthy citizen are imagined and produced in different national contexts. While the importance to a critical medical humanities of attending to cultural and historical specificity is articulated across the volume, this section engages most explicitly with 'the global'. Addressing multiple sites of healthcare, chapters by Bradby, Atkinson and Jolly further interrogate the uneven flows of knowledge, power, bodies, expertise and organs, between them highlighting the capacity of the critical medical humanities to illuminate alliances between biomedical interventions and neo-colonising philosophies and practices'.[55] 'Health, Care, Citizens' widens the scope of possible

sources for thinking about health and pathology – Harpin turns to the Broadmoor hospital archive to explore what the history of performance reveals about shifting notions of care, risk and therapy; Sabroe and Withington to the digitised corpus of early modern texts to trace changing notions of 'counsel' – but it also showcases new approaches to the more familiar resources of the medical humanities, such as the literary novel. Atkinson, as a social scientist, 'attend[s] specifically to the issues, rhetoric and modes of argumentation mobilised or disclosed within different imagined scenarios' in her engagement with literary fiction,[56] while Burke develops a 'symptomatic reading' of contemporary novelistic and autobiographical accounts of dementia care to understand them not as cultivating compassion and empathy, but rather as manifesting a violence that is profoundly ideological.

Alternative Trajectories through *The Companion*

The Edinburgh Companion to the Critical Medical Humanities is organised thematically in order to highlight key areas of cross-disciplinary interest and activity within critical medical humanities scholarship. However, there are a myriad of alternative pathways through a volume of this size and diversity; here, we outline three other reading trajectories formed by disciplinary specialism, historical period and a broadly spatial or geographical approach. These alternate routes were consciously mapped out by the editorial team and informed our thinking about the shape and scope of the different sections. Less predictable were the further topics of interest that emerged across and between the chapters, surfacing as important sites of concern for the critical medical humanities as the volume took shape. This section will therefore close by addressing a cross-cutting thematic interest in questions of violence, and signalling thematic and methodological concerns around questions of authority and expertise.

Disciplinary Pathways

While many of the chapters already bear the hallmarks of interdisciplinary entanglement, literature, philosophy, visual culture, history and the social sciences emerge as the dominant disciplinary specialisms of *The Companion*. Literature has played a significant role in the medical humanities to date, and *The Companion* demonstrates that it also has an important place in the critical medical humanities, although – as explained above – with a shift in emphasis from literature's, and especially narrative's, representational capacity to more self-reflexive questions of form and function.[57] The question of empathy, also central to the narrative turn in the first wave of the medical humanities, is negotiated in a group of chapters that argue for the efficacy of a strategic refusal or denial of empathy in texts that navigate a complex and contested politics of care (Atkinson, Burke, Jolly). Turning to a more methodological focus, Herman's chapter illuminates the potential of narratology in the context of the critical medical humanities; his specific focus is on animal–human interactions, but the recent rise of cognitive literary studies has signalled the broader potential for narratological literary

studies to intervene in current debates on the human mind and cognition.[58] A final subset of chapters ask what contribution the history of reading might make to the medical humanities: Garratt probes nineteenth-century theories of reading and health, Richards and Wistreich consider the significance of voice in the history of reading aloud, and Saunders (re)views contemporary neuroscience through the lens of reading and affect in the medieval period. Collectively, then, the chapters in *The Companion* with a distinctively literary focus both fix a critical eye back on the narrative turn in the medical humanities to date, moving away from a model in which the literary text is seen to stand as a straightforward representation of and mode of access to the experience of illness, and signal the potential for new approaches and areas of inquiry.

Philosophy, like literature, has closely informed the first wave of the medical humanities. We have discussed above the ongoing importance of phenomenology to the field, indicating the ways in which contributors to *The Companion* are opening up new ground: key chapters here are by Rehmann-Sutter and Mahr, Jones, Kelly and Magi, Macnaughton and Carel, Juler, Cole and Gallagher, Guenther and Salisbury. Philosophy also draws attention to the potential, and the limits, of bodily materiality: Martyn Evans assesses the place of wonder in grasping the complexities of human embodiment, while Dolezal turns a critical gaze on discourses of freedom in theorisations of the posthuman body.

History has also taken a leading role in the medical humanities, and here too *The Companion* is interested in tracking the ways in which it is pushing into new territories and opening up new perspectives. While we focus under 'historical pathways' below on the important contributions to the critical medical humanities being made by scholars in the medieval and early modern periods and in the long nineteenth century, vital work is being carried out across the full historical range and spectrum. New methodologies are also reorienting medical history in relation to the materiality of evidence, with the digital humanities and changing approaches to the archive leading to innovative and collaborative, cross-disciplinary projects; the new opportunities that this brings to the field are addressed by Kassell, Klestinec, and Sabroe and Withington.

The Companion deliberately places literary, philosophical and historical approaches alongside, and in conversation with, arts and humanities disciplines that have not been as influential in the medical humanities to date. Visual culture, which encompasses the disciplinary fields of museum studies and art history and practice, is attentive to how the visual arts can help us to (re)conceptualise the body and to probe its position and status within the biomedical imaginary: Biernoff thinks in this context about the representation of pain, Juler about the bodily interior, and Allen about the cadaver. Other chapters attend closely to the visualising technologies of medicine, asking how they construct the subject of their gaze: here, Andrews and Metzl, and Tilley and Olsén both return to the nineteenth century as a key historical moment when such technologies, so pervasive in biomedicine today, were still in formation.

If mainstream medical humanities has been largely defined by its championing of the arts and humanities disciplines, the critical medical humanities, we suggest, embraces and is energised by the social sciences, and in particular sub-disciplinary

areas, such as health geography,[59] with a long-standing critical engagement with matters medical. Key chapters here include critiques of public health discourses by Bradby and by Evans and Cooper, as well as the careful and nuanced attention to a politics of care demonstrated by Rebecca Hester in relation to 'cultural competence' in medicine, and by Atkinson in the context of the global organ trade. *The Companion* indicates what the humanities might learn from the social sciences in medical humanities interactions, and conversely how the social sciences might be enriched by engagement with the humanities: historian Withington accordingly draws on the big data methodologies more conventionally associated with the social sciences, while health geographer Atkinson persuasively argues the case for the value of imaginative literature.

The editors explicitly invited contributors to reflect on how particular disciplines are responding to, and (re)conceiving their place within, the medical humanities, in part with a view to generating debate and discussion across and between disciplines. These debates are integral to the project of the medical humanities and inform many cross-disciplinary collaborations in the field. An important grouping of chapters is those written by contributors, often from very different subject areas, whose work is marked by a commitment to collaborative thinking: see, for example, Fitzgerald and Callard, Cole and Gallagher, Sabroe and Withington, and Macnaughton and Carel. In reflecting on their own logics of interdisciplinarity, these chapters signal the new questions that can be asked in and through such work: questions that might not have been possible when working within a medical or a humanities discipline alone.

Historical Pathways

Thinking and reading historically is, we have already suggested, vital to the project of the critical medical humanities, and a second pathway through the volume highlights two clusters of chapters: those looking at the medieval and early modern periods, and those situated in the long nineteenth century. Pre-Cartesian perspectives on the mind and body offer a key vantage point from which to view, and to historicise in turn, contemporary biomedicine. Saunders turns to the medieval thought world to bring a long historical and cultural perspective to voice hearing, and visionary and hallucinatory experience, identifying in a range of secular and religious texts a suggestive resource for both countering and enriching current models and understandings of these phenomena. Richards and Wistreich turn to the Renaissance anatomy theatre to resituate ideas of voice, text and authority, and Klestinec explores the role and importance of touch in the medical relation. Notably, the historical perspective becomes a vital means through which the predominance of the visual in biomedicine can be contested, and other bodily senses and faculties rise to prominence. Work in the early modern period also portrays a medical institution at a time of rapid transition or change, a useful reminder that biomedicine is itself historically contingent, as well as contested and volatile. As previously discussed, Kassell, Klestinec, and Sabroe and Withington all use the transitional aspect of early modern medicine to different, but complementary, effect.

Chapters grouped in the long nineteenth century harness the historical in a slightly different mode: here, it is not that then-contemporary medical thinking and practice offer an alternative perspective on the biomedical, but rather that modernity itself is taking shape in this period and we can therefore examine biomedicine at a point when it is still emerging. One group of chapters focuses on the physical treatments of the period: Tilley and Olsén's exploration of nineteenth-century technologies for the blind thus reads instructively alongside Andrews and Metzl on the racial discourses embedded in nineteenth-century medical imaging techniques, Viney on the racial and eugenic underpinnings of late nineteenth- and early twentieth-century experimentation on twins, and Harpin on the history of theatre production at Broadmoor. Each of these contributors pays careful attention to the imbrication of the medical and the disciplinary, which can have at times surprising and unpredictable effects. A parallel subset of chapters focuses on the development of psychiatric discourses in the long nineteenth century: here, Garratt brings into view the intense engagement of Victorian scientific and psychiatric thought with literature and the aesthetic, and Salisbury continues this dialogue between medical science and the humanities into a discussion of late nineteenth- and early twentieth-century neurology, drawing out its complex intersection with the literary aesthetics of modernism that emerged simultaneously. Extrapolating out from the attention of Garratt and Salisbury to the investment of nineteenth-century scientific thought with and in the humanities, it can be noted that, throughout *The Companion*, reading historically presses on the concept of the medical humanities as a new phenomenon: a long temporal perspective reveals that the medical humanities should be conceived as integral, and indeed central, to the tradition of Western thought, which repeatedly entangles scientific and humanistic approaches to develop complex ideas relating to evidence, body, affect, mind and care.

Spatial Pathways

A third reading trajectory through *The Companion* can be defined as offering a broadly spatial perspective. Here, two distinct, but complementary, lines of inquiry emerge: the first considers what it means to engage with the medical humanities in the context of globalisation, and the second looks at the sites and spaces opened up by the critical medical humanities. There has been a recent move in the medical humanities towards a critique of the Western-centred focus of the field to date; debate has, however, largely centred on the teaching of medical practitioners, and on expanding the canon of humanities texts that might be used in this context, to include postcolonial authors and/or works by indigenous writers.[60] Specifically, little has been done to contest or complicate a binary of the 'West and the rest', to think through in more complex terms the messy and uneven entanglement of subjects that globalisation inevitably entails. The first subset of chapters in this category therefore addresses medicine and globalisation with a particular emphasis on mapping or charting the movements and migrations – of people, of bodily organs and of concepts – that define the current landscape of healthcare. Bradby and Atkinson focus

on the global movement of medical 'resource' and consider how an interdisciplinary approach might help to open up contemporary debates around a scarcity of resource and unequal availability and access to it. Chapters by Scheid, Jolly and Hester focus on the migration of concepts or ideas, and the limits or risks that are entailed when one world view meets or intersects with another. Scheid outlines three parallel histories of the concept of 'holism', tracing its complex and at times controversial rise to prominence in Chinese medicine and in systems biology, before critiquing the claims for a personalised medicine of current integrationists of the two models, arguing that the resulting science is much more reductionist than its proponents claim. Jolly and Hester are both concerned, at different scales, with the question of cultural competence. Jolly problematises the notion at a global level, by identifying the postcolonising terms on which biomedical aid is offered to indigenous subjects, meaning that access to healthcare is typically obtained through a renunciation of cultural identity (Fanon comes back into view here as a timely intellectual companion).[61] Hester adopts a national focus, taking issue with cultural competence in medical training, predominantly in the US, although with an increasing global influence, arguing that claims for increased knowledge of cultural Others is as likely to lead to more, not less, inequity, exploitation and abuse of patients from non-dominant backgrounds. Running across the chapters by Scheid, Jolly and Hester is a common concern to position biomedicine as a single, albeit dominant, paradigm, which should be placed in context with, and relativised by, alternative models; in this sense, the geographical or spatial axis provides a parallel to the historical frame discussed in the preceding paragraphs, in offering an effective standpoint for critique.

The second subset of chapters with a spatial focus opens up the question of the medical site. At the beginning of this Introduction, we outlined the 'primal scene' of the medical humanities, arguing that the field has been particularly invested in the clinical scenario of communicating to a cancer patient news of her life-threatening illness. Fitzgerald and Callard focus their gaze on another, equally charged site, which again involves potentially terminal, end-of-life care: the patient on the life support machine. They observe of the potential for the critical medical humanities to open up to view a range of alternative medical spaces:

> Within such an imaginary, one could argue that the most pressing sites of the biopolitical redistribution of bodily potencies (with all that they connote in relation to questions of medicine and health) might not include the bioethically over-invested scene of the prone figure hooked up to a life support machine; one might then explore, instead, assemblages of welfare policies, psychometric tests, affective dispositions and algorithmic predictions that are in the process of redistributing categories and manifestations of productive labour and idleness under practices of 'workfare'. Or, to take another example, one might approach a healthcare 'institution' not as a conceptual and physical edifice whose histories we have become used to tracing (the NHS, the World Health Organisation, the hospital), but as something that gives form or order precisely by 'cutting' or 'disentangling' entities from a heterogeneous field.[62]

Fitzgerald and Callard remind us that the 'sites' of medicine are not necessarily spatial, but can include policies (see, for example, Bradby) or the 'site' of the diagnosis itself (see Andrews and Metzl on drapetomania, or Evans and Cooper on fatness). Acknowledging the importance of expanding our notion of what might constitute a medical 'site', it is nevertheless instructive in the context of *The Companion* to pause and consider the range of physical spaces that the contributors open up and enter into. A poignant, and pointed, counterpoint to Fitzgerald and Callard's patient on the life support machine is Guenther's executed prisoner of the US penal system, whose prone body occupies centre-stage in a theatre that mimics as closely as possible the apparatus and rituals of end-of-life care. Guenther's analysis of the staging of the execution, as well as of the politics of access to the space, in turn speaks powerfully to Allen's reflections on the spaces of the morgue and the tissue laboratory, and to Dolezal on the plastic surgery operating theatre; indeed, both Allen and Dolezal point to the attraction of such spaces for contemporary performance artists, with French artist Orlan a figure of particular interest. Other chapters focus on the research laboratory as a key site for the critical medical humanities, marking a conscious and deliberate move away from the clinical and pedagogical focus of the first wave of medical humanities: see, for example, Carusi or Viney. The volume also registers the ways in which health, medical and clinical concerns and discourses spill out beyond the sites over which the health sectors and system have direct jurisdiction, and into the values, morality and experiences of everyday spaces (see, for example, Burke, Dolezal, Evans and Cooper, Herman, and Rehmann-Sutter and Mahr).[63] In expanding either the concept of the medical site, or the range of spaces that might be designated as such, the point, as Fitzgerald and Callard note, is not simply 'to introduce a new range of topics',[64] or indeed of topoi, that might be designated as coming under the purview of the medical humanities; it is not, in other words, a colonising venture. Rather, the importance of attending to such sites would be to interrogate what sites and/or spaces come to matter, and with what material and political effects; to think about what other sites and spaces are thereby obscured from view; and to probe critically the range of human and non-human intra-actions and material practices that take place within these spaces, noting in particular which bodies come to count, or are discounted, by and through them.

Violence

The theme of violence emerged as an area of particular concern for the critical medical humanities as the chapters of *The Companion* were read in conjunction with each other. For contributors taking a more oppositional stance to biomedicine, violence is perceived to be institutional and systemic, and is positioned as integral to the (neo) colonial, legal, social and economic underpinnings of contemporary healthcare systems. Chapters by Atkinson, Burke and Hester move between personal stories or experiences of suffering and the medical institutions that (fail to) respond to and treat this distress. The point is not to contribute to or perpetuate a culture of blame, which wrongly singles out individuals as targets of attack, but rather to pressure the concept

of care by asking us to extrapolate out from narratives of individual pain to broader political questions and concerns. Contributors writing from the perspective of philosophy and of visual culture – including Allen, Biernoff and Dolezal – bring an alternative focus to the theme, attending to the often troubled (and troubling) question of the artistic representation of violence and pain, which inevitably touches on issues of aesthetics, and even of beauty.[65] Another powerful grouping of chapters aligns with a notion of the critical that is embedded in a politics of implication. Here, the designation of the boundary between human and non-human, and its material and tangible effect on which bodies are seen to count as deserving of rights and protection, and which are not, becomes crucial. Harpin and Guenther address the implications of the incarcerated body, which is denied citizenship and which therefore occupies a site of vulnerability to potential violence and harm. Giorgio Agamben's notion of the *homo sacer* becomes particularly resonant in this context, in its identification of a body that is deprived of rights and that can be killed, without the killer being regarded as a murderer;[66] Guenther's executed prisoner could be designated within this category, as could the dark side of Viney's twin research, most famously exemplified by Joseph Mengele's twin experiments at Auschwitz concentration camp in the Second World War. Although Herman does not address the highly charged issue of animal experimentation in medical research, this topic raises not only the spectre of the *homo sacer* but also the questions of agency, affect and feeling that are central to *The Companion*. The issue of which bodies come to matter, and more crucially, which do not, will be ever more central to the medical humanities as we move increasingly towards a bioscience that operates in terms of what Susan Merrill Squier has aptly named 'liminal lives': including, amongst others, in vitro embryos and cellular and tissue cultures.[67]

Authority and Expertise

The final category that has surfaced as central to the current concerns of the medical humanities is the question of authority or expertise. This has been a (if not the) dominant issue in the first wave of the medical humanities, which has taken much of its impetus from a shifting of authority from the doctor's professional expertise to the patient's experience, with the illness narrative a key vehicle for achieving this transition of authority.[68] The oppositional chapters in *The Companion* continue this politics, although crucially with an emphasis less on individual patient experience and more on broader institutional and systemic problems. Thus, if Guenther, Hester and Jolly all position biomedical knowledge as a potentially harmful, if not violent, form of authority, then this is because of its legal, social and colonial underpinnings. Equally, where contributors stress the importance of 'lay knowledge' to medical understanding, there is a notable move away from an empathetic reading of the illness narrative and an opening up of the knotted and complex problems of form and function. Central to this discussion is the chapter by Magi, Jones and Kelly, which takes up the question of first-person experience in the context of psychiatric discourse. The authors are unequivocal about the value of 'patient' experience in and for psychiatric medicine,

as well as about its overall absence to date: 'Certain modalities, experiences, versions or variants of "symptoms" are regularly privileged or fetishised – and those who control these terms and constructs and their academic lives, are rarely if ever themselves mad.'[69] Nevertheless, voicing 'the patient perspective' is no simple or straightforward matter. On the one hand, Magi, Jones and Kelly point to the important issue of representativeness, asking to what extent one person's experience can or should be taken to stand for that of others:

> You have enduring concerns about representation and situated knowledge claims.
>
> You may indeed know something from living with psychosis.
>
> You have concerns about the risks of essentialism implicit in these sorts of knowledge.
>
> Your experimental or theoretical pursuits may be more a reflection of your particular proclivities and less an affect of your status as psychotic subjects.[70]

On the other hand, the authors trouble the issue of representation itself, noting (like Salisbury) that the forms of academic and narrative writing do not necessarily offer the most appropriate vehicles for conveying the illness experience: 'Here, to . . . refashion is a poetics of care: it was no longer possible to keep on addressing imagined readers with the same language sequences, spacing, syntax, thesis and conclusion structure that had so often trapped us.'[71] Here, then, there is a close attention to how alternative forms of authority might be written and read: a question that is also taken up by Herman, as he asks why the scientific case study acts as a privileged mode of discourse in comparison to the literary form of the anecdote. Running across *The Companion*'s various engagements with the question of expertise, a further shift might also be discerned in terms of intended or implied addressee: if the first wave of the medical humanities regarded the primary recipient of the illness narrative to be the clinical practitioner, who would then deliver a more empathetic and understanding mode of treatment, the critical medical humanities also aims to reach and interact with medical research, be that in the context of genetics (Rehmann-Sutter and Mahr) or of psychiatry (Magi, Jones and Kelly), and to influence questions of policy and of diagnosis.

We have already identified the realignment of expertise as central to the question of entanglement. As noted above, a fundamental recalibration of authority can be discerned in Carusi's location of agency in science's objects as well as in the human researcher, and in Herman's analysis of the role and agency of the animal in animal-assisted therapies. A longer historical view can also shed light on why and how certain modes of medical authority have come to matter more than others. Klestinec remarks suggestively that as scientific authority has become aligned with the visual, the authoritative gaze of the (male) doctor has taken precedence over the touch of the midwife, and she advocates that one task for the critical medical humanities might be to enquire into how the relations between, and appropriations of, the senses inform questions of hierarchy and authority. Relatedly, Richards and Wistreich open up a historical perspective on 'lay' knowledge and expertise by attending to the role and importance of voice, while Sabroe and Withington examine the word 'counsel' from a cross-period

perspective to draw out shifts of authority in the clinical encounter. Entanglement also informs a final aspect of authority and expertise with which the critical medical humanities is centrally engaged: the question of interdisciplinarity. This volume asks how modes of collaborative and cross-disciplinary working might negotiate the challenges to academic and disciplinary expertise that are inevitably entailed. Equally, we think about how large research projects that draw in and on academic, medical and 'lay' expertise can navigate problems and assumptions related to institutional hierarchies and privileges. Here, again, there is (and can be) no single or simple response, but the complexities that the issues raise for the field are eloquently addressed in the opening chapter by Fitzgerald and Callard, which elaborates the concept of entanglement to indicate one productive way forwards. Reading across the volume, it is clear that issues of authority and expertise will remain vital, invigorating and animating topics (and topoi) for the medical humanities, as the field continues to negotiate and to challenge disciplinary, institutional and political boundaries and hierarchies, and to interrogate how and why some bodies, discourses and practices have come to matter more than others.

This Introduction has mapped out a number of routes for readers of the volume to follow, although there are of course innumerable alternative pathways that could be taken. Our hope is that these suggested trajectories will assist readers of many disciplines, and of interdisciplinary endeavour, to engage with the volume. *The Companion* includes contributions not only by scholars who are well established in medical humanities but also by academics and practitioners who are new to the area; we have likewise invited chapters from early career researchers alongside more senior figures. In doing so, we have sought throughout the editorial process to remain faithful to a forward-facing vision of, and commitment to, scholarship within the field. Our aim is to gather together the most exciting voices and ideas currently defining the medical humanities, in the anticipation that this will generate a critical momentum in the field, and provide in turn a launch point for further waves of the medical humanities yet to come.

Notes

1. The term biomedicine is used advisedly and refers to the evidence-based scientific model of medicine that originates in the West and has come to dominate global healthcare from the latter half of the twentieth century.
2. With thanks to Jane Macnaughton for drawing our attention to the importance of successive waves.
3. Questions of the history, purpose and value of the medical humanities (particularly as perceived by the medical establishment) have come sharply into focus in recent years and are comprehensively addressed in a number of important publications: Johanna Shapiro, Jack Coulehan, Delese Wear and Martha Montello, 'Medical Humanities and Their Discontents: Definitions, Critiques, and Implications', *Academic Medicine: Journal of the Association of American Medical Colleges* 84.2 (2009), pp. 192–8; Howard Brody, 'Defining the Medical Humanities: Three Conceptions and Three Narratives', *Journal of Medical Humanities* 32.1 (2011), pp. 1–7; Brian Hurwitz, 'Medical Humanities: Lineage, Excursionary Sketch

and Rationale', *Journal of Medical Ethics* 39.11 (2013), pp. 672–4; Victoria Bates and Sam Goodman, 'Critical Conversations: Establishing Dialogue in the Medical Humanities', in Victoria Bates, Alan Bleakley and Sam Goodman (eds), *Medicine, Health and the Arts: Approaches to the Medical Humanities* (Abingdon: Routledge, 2014), pp. 3–13; Therese Jones, 'Oh! The Humanit(ies)! Dissent, Democracy, and Danger', *Medicine, Health and the Arts*, pp. 27–38; Alan Bleakley and Therese Jones, 'Appendix: A Timeline of the Medical Humanities', *Medicine, Health and the Arts*, pp. 281–4; Therese Jones, Delese Wear and Lester D. Friedman, 'The Why, What, and How of the Health Humanities', in *Health Humanities Reader* (New Brunswick, NJ: Rutgers University Press, 2014), pp. 1–9; Alan Bleakley, *Medical Humanities and Medical Education: How the Medical Humanities Can Shape Better Doctors* (London and New York: Routledge, 2015).

4. The prominence of cancer within mainstream medical humanities is reflected by the enduring influence of Susan Sontag's work, and has recently been taken up by Paul Crawford et al., who note the uneven distribution of interest across health conditions in the field. Susan Sontag, *Illness as Metaphor* (New York: Farrar, Straus & Giroux, 1978); Barbara Clow, '"Who's Afraid of Susan Sontag?" or, the Myths and Metaphors of Cancer Reconsidered', *Social History of Medicine* 14.2 (2001), pp. 293–312; Paul Crawford, Brian Brown, Victoria Tischler and Brian Abrams, *Health Humanities* (Basingstoke: Palgrave Macmillan, 2015), p. 80.
5. See Brody, 'Defining the Medical Humanities', pp. 1–7.
6. Robert Arnott, Gillie Bolton, Martyn Evans, Ilora Finlay, Jane Macnaughton, Richard Meakin and William Reid, 'Proposal for an Academic Association for Medical Humanities', *Journal of Medical Ethics: Medical Humanities* 27 (2001), pp. 104–5.
7. Ibid., p. 105.
8. Bradley Lewis, 'Reading Cultural Studies of Medicine', *Journal of Medical Humanities* 19.1 (1998), pp. 9–24 (p. 9).
9. See Alan Bleakley, *Medical Humanities and Medical Education: How the Medical Humanities Can Shape Better Doctors* (London and New York: Routledge, 2015) for a recent work that begins to address how a critical medical humanities might inform medical education.
10. Arthur Kleinman, *The Illness Narratives: Suffering, Healing and the Human Condition* (New York: Basic Books, 1988).
11. Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford: Oxford University Press, 2006); Katherine Montgomery, *Doctor's Stories: The Narrative Structure of Medical Knowledge* (Princeton: Princeton University Press, 1995).
12. Angela Woods, 'The Limits of Narrative: Provocations for the Medical Humanities', *Medical Humanities* 37 (2011), pp. 73–8; see also Claire McKechnie, 'Anxieties of Communication: The Limits of Narrative in the Medical Humanities', *Medical Humanities* 10 (2014), pp. 1–6.
13. See Paul Robertson, 'Music, Therapy and Technology: An Opinion Piece', *Medicine, Health and the Arts*, pp. 2237–45; Ian C. Williams, 'Graphic Medicine: The Portrayal of Illness in Underground and Autobiographical Comics', *Medicine, Health and the Arts*, pp. 64–84.
14. Jeffrey Bishop, 'Rejecting Medical Humanism: Medical Humanities and the Metaphysics of Medicine', *Journal of Medical Humanities* 29 (2008), pp. 15–25 (p. 15).
15. See Sarah Atkinson in this volume; see also Sarah Atkinson, Jane Macnaughton, Corinne Saunders and Martyn Evans, 'The Art of Medicine: Cool Intimacies of Care for Clinical Practice', *The Lancet* 376 (2010), pp. 1732–3.

16. For further recent discussion of the critical medical humanities, see also Sarah Atkinson, Bethan Evans, Angela Woods and R. Kearns, ' "The Medical" and "Health" in a Critical Medical Humanities', *Journal of Medical Humanities* 36 (2015), pp. 71–81. The term has also been elaborated, to different effect, by Alan Bleakley; see Bleakley, 'Towards a "Critical Medical Humanities" ', *Medicine, Health and the Arts*, pp. 17–26.
17. William Viney, Felicity Callard and Angela Woods, 'Critical Medical Humanities: Embracing Entanglement, Taking Risks', *Medical Humanities* 41 (2015), pp. 2–7 (p. 3).
18. Ibid.
19. Volker Scheid, 'Holism, Chinese Medicine and Systems Ideologies: Rewriting the Past to Imagine the Future', in this volume, p. 82.
20. For an illuminating discussion of Fanon and medicine, see Hussein Abdilahi Bulhan, *Frantz Fanon and the Psychology of Oppression* (New York: Plenum Press, 1985).
21. Particular thanks to Jennifer Richards for her framing of this paragraph.
22. Sara Ahmed, *The Promise of Happiness* (Durham, NC: Duke University Press, 2010).
23. Viney et al., 'Critical Medical Humanities: Embracing Entanglement, Taking Risks', p. 4.
24. Karen Barad, *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning* (Durham, NC: Duke University Press, 2007), p. 26.
25. Des Fitzgerald and Felicity Callard, 'Entangling the Medical Humanities', in this volume, p. 35.
26. Annamaria Carusi, 'Modelling Systems Biomedicine: Intertwinement and "the Real" ', in this volume, p. 51.
27. William Viney, 'Getting the Measure of Twins', in this volume, p. 114.
28. Mel Y. Chen, *Animacies: Biopolitics, Racial Mattering and Queer Affect* (Durham, NC: Duke University Press, 2012).
29. Viney, 'Getting the Measure of Twins', p. 116.
30. For a suggestive collection that combines feminism and phenomenology, see Kristin Zeiler and Lisa Folkmarson Kall (eds), *Feminist Phenomenology and Medicine* (New York: SUNY Press, 2014).
31. See, for example, Shaun Gallagher and Dan Zahavi, *The Phenomenological Mind* (London: Routledge, 2008); Shaun Gallagher, *How the Body Shapes the Mind* (Oxford and New York: Oxford University Press, 2005).
32. Jill Magi, Nev Jones and Timothy Kelly, 'How Are/Our Work: What, if Anything, is the Use of This?', in this volume, p. 151.
33. It is notable that the extension of phenomenology to pain management, drawing on first-person accounts of pain, is coincident with Joanna Bourke's influential challenge to Elaine Scarry's account of pain as incommunicable. See, respectively, Joanna Bourke, *The Story of Pain from Prayer to Painkillers* (Oxford: Oxford University Press, 2014); Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (Oxford: Oxford University Press, 1985).
34. Margrit Shildrick, 'Critical Disability Studies: Rethinking the Conventions for the Age of Postmodernity', in Nick Watson, Alan Roulstone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Abingdon: Routledge, 2012), pp. 30–41. See also Rebecca Mallett and Katherine Runswick-Cole, *Approaching Disability: Critical Issues and Perspectives* (Abingdon: Routledge, 2014); Helen Meekosha and Russell Shuttleworth, 'What's So Critical About Critical Disability Studies?', *Australian Journal of Human Rights* 15.1 (2009), pp. 47–75.

35. For a fuller discussion of this shift in critical disability studies and its implications, see Dan Goodley, 'Dis/entangling Critical Disability Studies', *Disability and Society* 28.5 (2013), pp. 631–44 (pp. 634–8).
36. Ibid., pp. 638–9.
37. The journal is titled the *Journal for Critical Animal Studies* and the monograph series is published by Brill/Rodopi.
38. See, for example, Mark Bekoff, *The Emotional Lives of Animals* (Novato, CL: New World Library, 2007); Jacob von Uexkull, *A Foray into the Worlds of Humans and Animals*, trans. Joseph D. O'Neil (Minneapolis and London: University of Minnesota Press, 2010); and Lorraine Daston and Gregg Mitman (eds), *Thinking with Animals: New Perspectives on Anthropomorphism* (New York: Columbia University Press, 2005).
39. For a collection of essays that explores the potential of feminist theory on care in relation to animal rights, see Josephine Donovan and Carol J. Adams (eds), *The Feminist Care Tradition in Animal Ethics: A Reader* (New York: Columbia University Press, 2007). See also Cass R. Sunstein and Martha C. Nussbaum (eds), *Animal Rights: Current Debates and New Directions* (Oxford and New York: Oxford University Press, 2006).
40. The widespread interest in human rights in the academy is evident in the number of dedicated research centres and institutes in this field, and the growth in specialist programmes. The area is concerned with the analysis of a range of human rights issues, including international justice, human rights in the context of global poverty/resource, atrocities and activism.
41. See, for example, Jane Bennett, *Vibrant Matter: A Political Ecology of Things* (Durham, NC, and London: Duke University Press, 2010); Diane Coole and Samantha Frost (eds), *New Materialisms: Ontology, Agency, and Politics* (Durham, NC, and London: Duke University Press, 2010).
42. See Elizabeth Grosz, *Becoming Undone: Darwinian Reflections on Life, Politics and Art* (Durham, NC, and London: Duke University Press, 2011); Donna J. Haraway, *When Species Meet* (Minneapolis and London: University of Minnesota Press, 2007); and Elizabeth A. Wilson, *Gut Feminism* (Durham, NC, and London: Duke University Press, 2015).
43. Stacy Alaimo and Susan Hekman, 'Introduction: Emerging Models of Materiality in Feminist Theory', in Stacy Alaimo and Susan Hekman (eds), *Material Feminisms* (Bloomington: Indiana University Press, 2008), pp. 1–22 (p. 4).
44. Brian Hurwitz, Trisha Greenhalgh and Vieda Skultans (eds), *Narrative Research in Health and Illness* (Malden, MA: BMJ Books, 2004); Trisha Greenhalgh, 'Narrative Based Medicine in an Evidence Based World', *BMJ: British Medical Journal* 318.7179 (1999), pp. 323–5; Trisha Greenhalgh and Brian Hurwitz, 'Narrative Based Medicine: Why Study Narrative?', *BMJ (Clinical Research Ed.)* 318.7175 (2 January 1999), pp. 48–50.
45. S. Kay Toombs, *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient* (Dordrecht: Kluwer Academic, 1993) <https://books.google.co.uk/books?id=GUfV3f2z4JMC&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false> (accessed 31 May 2015); S. Kay Toombs (ed.), *Handbook of Phenomenology and Medicine*, Philosophy and Medicine vol. 68, (Dordrecht: Springer Netherlands, 2001); Havi Carel, *Illness: The Cry of the Flesh*, revised edition (London: Routledge, 2014).
46. Crawford et al., *Health Humanities*.
47. Bleakley, *Medical Humanities and Medical Education*.
48. Fitzgerald and Callard, 'Entangling the Critical Medical Humanities', p. 45.

49. Magi et al., 'How Are/Our Work', p. 136.
50. Maxine Sheets-Johnstone, *The Corporeal Turn: An Interdisciplinary Reader* (Exeter and Charlottesville, VA: Imprint Academic, 2009).
51. Jonathan Reinarz and Kevin Siena, *Past Scents: Historical Perspectives on Smell* (Champaign: University of Illinois Press, 2014); Jonathan Reinarz (ed.), *A Medical History of Skin: Scratching the Surface* (London: Pickering & Chatto, 2013); Steven Connor, *The Book of Skin* (London: Reaktion; Ithaca, NY: University of Cornell Press, 2004).
52. Corinne Saunders, 'Voices and Visions: Mind, Body and Affect in Medieval Writing', in this volume, p. 411.
53. See, for example, the journal *Literature and Medicine*, founded in 1982 by the Johns Hopkins University Press, and the Arts and Humanities Research Council (AHRC)-funded Madness and Literature Network <http://www.madnessandliterature.org/> (accessed 3 July 2015).
54. Peter Garratt, 'Victorian Literary Aesthetics and Mental Pathology', in this volume, p. 430.
55. See in particular Rosemary J. Jolly, 'Fictions of the Human Right to Health: Writing Against the Postcolonialising Exotic in Western Medicine', in this volume, pp. 527–40.
56. Sarah Atkinson, 'Care, Kidneys and Clones: The Distance of Space, Time and Imagination', in this volume, p. 611.
57. Anne Whitehead, 'Medical Humanities: A Literary Perspective', in *Medicine, Health and the Arts*, pp. 101–27.
58. See, for example, Simon Jacques Juleen (ed.), *Cognitive Literary Studies: Current Themes and New Directions* (Austin: University of Texas Press, 2013); Lisa Zunshine (ed.), *The Oxford Handbook of Cognitive Literary Studies* (Oxford and New York: Oxford University Press, 2015); Lars Barmaerts, Dirk de Geest, Luc Herman and Bart Vervaeck (eds), *Stories and Minds: Cognitive Approaches to Literary Narrative* (Lincoln, NB: University of Nebraska Press, 2013); Gary D. Fireman, Ted E.McVay and Owen J. Flanagan (eds), *Narrative and Consciousness: Literature, Psychology and the Brain* (New York and Oxford: Oxford University Press, 2003).
59. See Sarah Atkinson, Ronan Foley and Hester Parr, 'Introduction: Spatial Perspectives and Medical Humanities', *Journal of Medical Humanities* 36.1 (2015), pp. 1–4; Sarah Atkinson, Victoria Lawson and Janine Wiles, 'Care of the Body: Spaces of Practice', *Social and Cultural Geography* 12.6 (2011), pp. 536–72; Sarah Atkinson, 'Scales of Care and Responsibility: Debating the Surgically Globalised Body', *Social and Cultural Geography* 12.6 (2011), pp. 623–37.
60. See, for example, Claire Hooker and Estelle Noonan, 'Medical Humanities as Expressive of Western Culture', *Medical Humanities* 37.2 (2011), pp. 79–84. 'Global Medical Humanities' was the designated theme of the 2013 Association of Medical Humanities Conference (University of Aberdeen).
61. See Frantz Fanon, 'Medicine and Colonialism', *Studies in a Dying Colonialism*, trans. Haaken Chevalier (London: Earthscan, 1989), pp. 121–46.
62. Fitzgerald and Callard, 'Entangling the Medical Humanities', p. 42.
63. Thanks to Sarah Atkinson for bringing this point to our attention.
64. Fitzgerald and Callard, 'Entangling the Medical Humanities', p. 42.
65. For more on this, see Corinne Saunders, Jane Macnaughton and David Fuller (eds), *The Recovery of Beauty: Arts, Culture, Medicine* (Basingstoke: Palgrave, 2015).
66. Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life*, trans. Daniel Heller-Roazen (Bloomington: Stanford University Press, 1998).

67. Susan Merrill Squier, *Liminal Lives: Imagining the Human at the Frontiers of Biomedicine* (Durham, NC, and London: Duke University Press, 2004). See also Kaushik Sunder Rajan, *Biocapital: The Constitution of Postgenomic Life* (Durham, NC, and London: Duke University Press, 2006) and Melinda Cooper, *Life as Surplus: Biotechnology and Capitalism in the Neoliberal Era* (Seattle and London: University of Washington Press, 2008).
68. See Arthur W. Frank, *The Wounded Storyteller* (Chicago: University of Chicago Press, 1995); Arthur Kleinman, *The Illness Narratives*; Rita Charon, *Narrative Medicine*.
69. Magi et al., 'How Are/Our Work', p. 138.
70. Ibid., pp. 144–5.
71. Ibid., p. 151.